

CERTIFICATE OF DEATH

Reg. Dist. No.

13768

13741

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE md b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Evans Last Baker		4. DATE OF DEATH Month Dec. Day 26, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1869
9. AGE (In years last birthday) yrs. 90		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Foreman. Penna. R.R.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Goodwin Baker		14. MOTHER'S MAIDEN NAME Eliza Lamar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. W. Ernest Baker, Havre de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Chronic Myocarditis - Chronic Endocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Chronic Endocarditis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 17, 1959 to Dec. 26, 1959 , that I last saw the deceased alive on Dec 26, 1959 and that death occurred at 3 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Post Office, 12/26	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-1959	
22c. NAME OF CEMETERY OR CREMATORY Principio Cemetery		22d. LOCATION (City, town, or county) (State) Principio Furnace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE See a. Patterson & Son, Perryville, Md.		24a. REC'D BY REGISTRAR DATE DEC 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

13768

13768

13768

13768

13768

13768

13768

13768

13768

13768

13768

13768

13768

13768

13768

13768

13768

13768

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13769

CERTIFICATE OF DEATH

Reg. Dist. No.

13742

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 15 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETA First ROSE Middle BANKS Last		4. DATE OF DEATH December 10 19 59 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE COCOE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24 1905 9. AGE (In years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE BANKS		14. MOTHER'S MAIDEN NAME SALLY McGaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address 833 N. Fayette	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular disease (c) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/4 , 19 58 , to 12/10 , 19 59 , that I last saw the deceased alive on 12/10 , 19 59 , and that death occurred at 5:55 M, from the causes and on the date stated above. A ADDRESS (Street, city or town, state) 569 Revolution St. Harford, Md. DATE SIGNED 12/10/59			
ACTUAL SIGNATURE George T. Stansbury		M.D. 569 Revolution St. Harford, Md.	
PHYSICIAN'S NAME (Type) George T. Stansbury			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/12/59	22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	22d. LOCATION (City, town, or county) (State) R.D. Bel Air, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring ADDRESS Tarring Funeral Home, Aberdeen, Md.		24a. REC'D BY REGISTRAR DEC 16 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Harris

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

• *Neodiplosis*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13784

CERTIFICATE OF DEATH

Reg. Dist. No.

13743

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Forest Hill		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walters Mill Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Forest Hill	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Blanche Middle B. Last Bedsaul		4. DATE OF DEATH Month December Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1903
9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-30-7221	
17. INFORMANT William M. Bedsaul, Rd. Box 307, Forest Hill, Md.		Address R.D.#7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis ? (c) ?		INTERVAL BETWEEN ONSET AND DEATH 14 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October , 1929, to December 8 , 1959, that I last saw the deceased alive on December 7 , 1959, and that death occurred at 6:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED December 8, 1959			
ACTUAL SIGNATURE Willard P. Hudson M.D. Forest Hill, Maryland December 8, 1959			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/10/59	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Foster, Bel Air, Md.		24a. REC'D BY REGISTRAR DATE DEC 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

3852

1001-01

1. *Journal of the American Medical Association*, 1964; 191: 1000-1001.

1877

44

Sworn to before me at the County of ... State of New York, this ... day of ... 1877.

Notary Public for the State of New York.

Subscribed and sworn to before me at the County of ... State of New York, this ... day of ... 1877.

Notary Public for the State of New York.

13771

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hanover</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>	
c. LENGTH OF STAY IN 1b <i>49 yrs.</i>		d. STREET ADDRESS <i>300 Superior</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Carmine Lionelli</i>		4. DATE OF DEATH <i>12/21/59</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 3, 1878</i>	
9. AGE (In years last birthday) <i>81</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Theresa Hanell, Hanover Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiac Decompensation</i> (c) <i>Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/20</i> , 19 <i>59</i> , to <i>12/21</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/21</i> , 19 <i>59</i> , and that death occurred at <i>7:00</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. H. Wollbrunn</i>		ADDRESS (Street, city or town, state) <i>407 S. ONION</i>	
PHYSICIAN'S NAME (Type) <i>Wm. H. Wollbrunn</i>		DATE SIGNED <i>12/24/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/24/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Eun</i>		22d. LOCATION (City, town, or county) (State) <i>Hanover Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. Wollbrunn</i>		24a. REC'D BY REGISTRAR <i>DEC 29 '59</i>	
ADDRESS <i>Hanover Md.</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

FILE NO.

DEATH
FILE NO.
1933
BALTIMORE, MD

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1888		BALTIMORE		MD		MD		USA	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		JAN 15 1910		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
LABORER		JAN 15 1910		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
HEART DISEASE		JAN 15 1933		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
NATURAL		JAN 15 1933		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
EDUCATION		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
HIGH SCHOOL		JAN 15 1910		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
RELIGION		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
CATHOLIC		JAN 15 1910		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
SIGNED		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JAMES H. HARRIS		JAN 15 1933		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
WITNESSED		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JAMES H. HARRIS		JAN 15 1933		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
FILED		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JAMES H. HARRIS		JAN 15 1933		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13746

Reg. Dist. No.

13772

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> 07x.2	
c. LENGTH OF STAY IN 1b <u>1 hour</u>		d. STREET ADDRESS <u>RD 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Stanton Dailey</u>		4. DATE OF DEATH <u>December 9</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/1929</u>
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Finance Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Harford Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry J. Dailey</u>		14. MOTHER'S MAIDEN NAME <u>Bayle Travis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>WW2</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mary L. Dailey</u>		Address <u>1001 Andy Lane, Wilton, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture femur</u> DUE TO (c) <u>Auto-tractor collision</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture femur</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Auto-tractor collision</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>12-9-59</u> Hour <u>12:05</u> a.m. <u>pm</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rte 40 & 152</u>		20f. (City or town) <u>Harford</u> (County) <u>Maryland</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md.</u> DATE SIGNED <u>12-9-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-14-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Md.</u>		22d. LOCATION (City, town, or county) <u>Harford</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Lee & Sons</u> ADDRESS <u>300 H St N.E.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH DEPT.
FOR STATE

17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Race: _____

5. Date of Birth: _____

6. Date of Death: _____

7. Place of Death: _____

8. Cause of Death: _____

9. Medical History: _____

10. Signature of Medical Examiner: _____

11. Signature of Coroner: _____

12. Signature of Registrar: _____

13. Signature of Physician: _____

14. Signature of Nurse: _____

15. Signature of Other: _____

16. Signature of Other: _____

17. Signature of Other: _____

18. Signature of Other: _____

19. Signature of Other: _____

20. Signature of Other: _____

21. Signature of Other: _____

22. Signature of Other: _____

23. Signature of Other: _____

24. Signature of Other: _____

25. Signature of Other: _____

26. Signature of Other: _____

27. Signature of Other: _____

28. Signature of Other: _____

29. Signature of Other: _____

30. Signature of Other: _____

31. Signature of Other: _____

32. Signature of Other: _____

33. Signature of Other: _____

34. Signature of Other: _____

35. Signature of Other: _____

36. Signature of Other: _____

37. Signature of Other: _____

38. Signature of Other: _____

39. Signature of Other: _____

40. Signature of Other: _____

41. Signature of Other: _____

42. Signature of Other: _____

43. Signature of Other: _____

44. Signature of Other: _____

45. Signature of Other: _____

46. Signature of Other: _____

47. Signature of Other: _____

48. Signature of Other: _____

49. Signature of Other: _____

50. Signature of Other: _____

51. Signature of Other: _____

52. Signature of Other: _____

53. Signature of Other: _____

54. Signature of Other: _____

55. Signature of Other: _____

56. Signature of Other: _____

57. Signature of Other: _____

58. Signature of Other: _____

59. Signature of Other: _____

60. Signature of Other: _____

61. Signature of Other: _____

62. Signature of Other: _____

63. Signature of Other: _____

64. Signature of Other: _____

65. Signature of Other: _____

66. Signature of Other: _____

67. Signature of Other: _____

68. Signature of Other: _____

69. Signature of Other: _____

70. Signature of Other: _____

71. Signature of Other: _____

72. Signature of Other: _____

73. Signature of Other: _____

74. Signature of Other: _____

75. Signature of Other: _____

76. Signature of Other: _____

77. Signature of Other: _____

78. Signature of Other: _____

79. Signature of Other: _____

80. Signature of Other: _____

81. Signature of Other: _____

82. Signature of Other: _____

83. Signature of Other: _____

84. Signature of Other: _____

85. Signature of Other: _____

86. Signature of Other: _____

87. Signature of Other: _____

88. Signature of Other: _____

89. Signature of Other: _____

90. Signature of Other: _____

91. Signature of Other: _____

92. Signature of Other: _____

93. Signature of Other: _____

94. Signature of Other: _____

95. Signature of Other: _____

96. Signature of Other: _____

97. Signature of Other: _____

98. Signature of Other: _____

99. Signature of Other: _____

100. Signature of Other: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13785

CERTIFICATE OF DEATH

Reg. Dist. No.

13747

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Frances Last Daughton		4. DATE OF DEATH Month December Day 24 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1888
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Practical	
11. BIRTHPLACE (State or foreign country) Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henrey Daughton		14. MOTHER'S MAIDEN NAME Katherine N. Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-28-3185	
17. INFORMANT Mrs. George E. Geyer		3115 Abell Ave. Balto. 18, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremis, terminating 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. cardiovascular-renal disease DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1958 , 19____, to December 24, 19 59 , that I last saw the deceased alive on Dec. 23 , 19 59 , and that death occurred at 9:00 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Willard P. Hudson M.D.		Forest Hill, Maryland December 26, 1959	
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/1959	
22c. NAME OF CEMETERY OR CREMATORY Jarrettsville		22d. LOCATION (City, town, or county) (State) Jarrettsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kutz		24a. REC'D BY REGISTRAR DATE DEC 29 '59	
ADDRESS Jarrettsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C. 20540

DATE OF BIRTH

1. NAME OF DECEASED JAMES EARL RAY		2. DATE OF BIRTH JAN 10 1928	
3. SEX Male		4. RACE White	
5. PLACE OF BIRTH Memphis, Tennessee		6. DATE OF DEATH JAN 4 1968	
7. TIME OF DEATH 10:15 AM		8. PLACE OF DEATH FBI Building, Memphis, Tennessee	
9. CAUSE OF DEATH Suicide		10. MANNER OF DEATH Homicide	
11. FULL NAME OF FATHER JAMES EARL RAY		12. FULL NAME OF MOTHER MADEIRA K. RAY	
13. FULL NAME OF SPOUSE JANET RAY		14. FULL NAME OF CHILDREN None	
15. FULL NAME OF NEXT OF KIN JAMES EARL RAY		16. FULL NAME OF NEXT OF KIN MADEIRA K. RAY	
17. FULL NAME OF NEXT OF KIN JANET RAY		18. FULL NAME OF NEXT OF KIN None	
19. FULL NAME OF NEXT OF KIN None		20. FULL NAME OF NEXT OF KIN None	
21. FULL NAME OF NEXT OF KIN None		22. FULL NAME OF NEXT OF KIN None	
23. FULL NAME OF NEXT OF KIN None		24. FULL NAME OF NEXT OF KIN None	
25. FULL NAME OF NEXT OF KIN None		26. FULL NAME OF NEXT OF KIN None	
27. FULL NAME OF NEXT OF KIN None		28. FULL NAME OF NEXT OF KIN None	
29. FULL NAME OF NEXT OF KIN None		30. FULL NAME OF NEXT OF KIN None	
31. FULL NAME OF NEXT OF KIN None		32. FULL NAME OF NEXT OF KIN None	
33. FULL NAME OF NEXT OF KIN None		34. FULL NAME OF NEXT OF KIN None	
35. FULL NAME OF NEXT OF KIN None		36. FULL NAME OF NEXT OF KIN None	
37. FULL NAME OF NEXT OF KIN None		38. FULL NAME OF NEXT OF KIN None	
39. FULL NAME OF NEXT OF KIN None		40. FULL NAME OF NEXT OF KIN None	
41. FULL NAME OF NEXT OF KIN None		42. FULL NAME OF NEXT OF KIN None	
43. FULL NAME OF NEXT OF KIN None		44. FULL NAME OF NEXT OF KIN None	
45. FULL NAME OF NEXT OF KIN None		46. FULL NAME OF NEXT OF KIN None	
47. FULL NAME OF NEXT OF KIN None		48. FULL NAME OF NEXT OF KIN None	
49. FULL NAME OF NEXT OF KIN None		50. FULL NAME OF NEXT OF KIN None	
51. FULL NAME OF NEXT OF KIN None		52. FULL NAME OF NEXT OF KIN None	
53. FULL NAME OF NEXT OF KIN None		54. FULL NAME OF NEXT OF KIN None	
55. FULL NAME OF NEXT OF KIN None		56. FULL NAME OF NEXT OF KIN None	
57. FULL NAME OF NEXT OF KIN None		58. FULL NAME OF NEXT OF KIN None	
59. FULL NAME OF NEXT OF KIN None		60. FULL NAME OF NEXT OF KIN None	
61. FULL NAME OF NEXT OF KIN None		62. FULL NAME OF NEXT OF KIN None	
63. FULL NAME OF NEXT OF KIN None		64. FULL NAME OF NEXT OF KIN None	
65. FULL NAME OF NEXT OF KIN None		66. FULL NAME OF NEXT OF KIN None	
67. FULL NAME OF NEXT OF KIN None		68. FULL NAME OF NEXT OF KIN None	
69. FULL NAME OF NEXT OF KIN None		70. FULL NAME OF NEXT OF KIN None	
71. FULL NAME OF NEXT OF KIN None		72. FULL NAME OF NEXT OF KIN None	
73. FULL NAME OF NEXT OF KIN None		74. FULL NAME OF NEXT OF KIN None	
75. FULL NAME OF NEXT OF KIN None		76. FULL NAME OF NEXT OF KIN None	
77. FULL NAME OF NEXT OF KIN None		78. FULL NAME OF NEXT OF KIN None	
79. FULL NAME OF NEXT OF KIN None		80. FULL NAME OF NEXT OF KIN None	
81. FULL NAME OF NEXT OF KIN None		82. FULL NAME OF NEXT OF KIN None	
83. FULL NAME OF NEXT OF KIN None		84. FULL NAME OF NEXT OF KIN None	
85. FULL NAME OF NEXT OF KIN None		86. FULL NAME OF NEXT OF KIN None	
87. FULL NAME OF NEXT OF KIN None		88. FULL NAME OF NEXT OF KIN None	
89. FULL NAME OF NEXT OF KIN None		90. FULL NAME OF NEXT OF KIN None	
91. FULL NAME OF NEXT OF KIN None		92. FULL NAME OF NEXT OF KIN None	
93. FULL NAME OF NEXT OF KIN None		94. FULL NAME OF NEXT OF KIN None	
95. FULL NAME OF NEXT OF KIN None		96. FULL NAME OF NEXT OF KIN None	
97. FULL NAME OF NEXT OF KIN None		98. FULL NAME OF NEXT OF KIN None	
99. FULL NAME OF NEXT OF KIN None		100. FULL NAME OF NEXT OF KIN None	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

13786 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13748

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) ROCKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER FALLS</u> <u>03X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 24</u>		d. STREET ADDRESS <u>BRADSHAW Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>DAVIDSON</u> Last <u>DAVIDSON</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 18, 1899</u> <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tool Makers</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID DAVIDSON</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA ROZETTE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-1329A</u>	
17. INFORMANT <u>MRS. HELEN SMITH, BEL AIR, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES</u> <u>SENILITY.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>3 WK'S</u> <u>OVER 1 YR</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 6</u> , 19 <u>59</u> , to <u>Dec 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 9</u> , 19 <u>59</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D. <u>302 HICKORY</u> <u>DEC 9, 1959</u> PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN M.D. BEL AIR, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-12-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Salem Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Falls Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lanahn Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 15 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES BERNARD DAYHOOF, JR.		4. DATE OF DEATH Month Day Year DECEMBER 9 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 5-1919
9. AGE (In years last birthday) 40 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAWMILL OPERATOR	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Thomas Dayhoof, Sr.		14. MOTHER'S MAIDEN NAME ALICE BEALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) II		16. SOCIAL SECURITY NO. 218-224713	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, rt 492 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis, liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 55 , to Dec , 19 59 , that I last saw the deceased alive on Dec 9 , 19 59 , and that death occurred at 550 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE T. Ralph Horley M.D.		DATE SIGNED Dec 9 1959	
PHYSICIAN'S NAME (Type) T. Ralph Horley MD Churchville Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-11/59	
22c. NAME OF CEMETERY OR CREMATORY Mt Zion Methodist		22d. LOCATION (City, town, or county) (State) Bel Air Harford Md Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Foster ADDRESS Bel Air, Md		24a. REC'D BY REGISTRAR DEC 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

13773

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

1914

1914

James

James

Male

White

Single

Single

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13750**

1
FOR STATE
HEALTH DEPT.

13774

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE	c. LENGTH OF STAY IN lb 1 hr, 45 min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT, Rural 07X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD MEMORIAL		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROLAND WILLARD DOWNIN JR.		4. DATE OF DEATH Month DEC Day 31 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH JUNE 1, 1944	9. AGE (In years last birthday) 15 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME ROLAND W. DOWNIN SR.		14. MOTHER'S MAIDEN NAME ROBERTA EBERHARDT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT ROLAND DOWNIN SR. (SAME)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BASAL SKULL FRACTURE C 822X DUE TO CONTUSION AND CONCUSSION BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 1 hr 45 min			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTO ACCIDENT ROLLED AUTO OVER	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 1015 DEC 31 1959	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HIGHWAY	20f. (City or town) (County) (State) RISING SUN, CECIL Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Philip W. Heuman		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PHILIP W. HEUMAN MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-3-1960	22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.
		22d. LOCATION (City, town, or county) (State) Colora, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		ADDRESS Perryville, Md.	24a. REC'D BY REGISTRAR DATE JAN 4 '60
		24b. REGISTRAR'S SIGNATURE Robert S. Thoma	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1970

1970

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. RACE</p>	
<p>5. DATE OF BIRTH</p>		<p>6. PLACE OF BIRTH</p>	
<p>7. DATE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. CAUSE OF DEATH</p>	
<p>11. MANNER OF DEATH</p>		<p>12. SIGNATURE OF MEDICAL EXAMINER</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF CORONER</p>	
<p>15. SIGNATURE OF JURY</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF RECORDER</p>	
<p>19. SIGNATURE OF ARCHIVER</p>		<p>20. SIGNATURE OF DISTRIBUTOR</p>	
<p>21. SIGNATURE OF DELIVERER</p>		<p>22. SIGNATURE OF DESTROYER</p>	
<p>23. SIGNATURE OF RECALLER</p>		<p>24. SIGNATURE OF RECOVERER</p>	
<p>25. SIGNATURE OF REPAIRER</p>		<p>26. SIGNATURE OF REPLACER</p>	
<p>27. SIGNATURE OF REFINER</p>		<p>28. SIGNATURE OF REFINER</p>	
<p>29. SIGNATURE OF REFINER</p>		<p>30. SIGNATURE OF REFINER</p>	
<p>31. SIGNATURE OF REFINER</p>		<p>32. SIGNATURE OF REFINER</p>	
<p>33. SIGNATURE OF REFINER</p>		<p>34. SIGNATURE OF REFINER</p>	
<p>35. SIGNATURE OF REFINER</p>		<p>36. SIGNATURE OF REFINER</p>	
<p>37. SIGNATURE OF REFINER</p>		<p>38. SIGNATURE OF REFINER</p>	
<p>39. SIGNATURE OF REFINER</p>		<p>40. SIGNATURE OF REFINER</p>	
<p>41. SIGNATURE OF REFINER</p>		<p>42. SIGNATURE OF REFINER</p>	
<p>43. SIGNATURE OF REFINER</p>		<p>44. SIGNATURE OF REFINER</p>	
<p>45. SIGNATURE OF REFINER</p>		<p>46. SIGNATURE OF REFINER</p>	
<p>47. SIGNATURE OF REFINER</p>		<p>48. SIGNATURE OF REFINER</p>	
<p>49. SIGNATURE OF REFINER</p>		<p>50. SIGNATURE OF REFINER</p>	
<p>51. SIGNATURE OF REFINER</p>		<p>52. SIGNATURE OF REFINER</p>	
<p>53. SIGNATURE OF REFINER</p>		<p>54. SIGNATURE OF REFINER</p>	
<p>55. SIGNATURE OF REFINER</p>		<p>56. SIGNATURE OF REFINER</p>	
<p>57. SIGNATURE OF REFINER</p>		<p>58. SIGNATURE OF REFINER</p>	
<p>59. SIGNATURE OF REFINER</p>		<p>60. SIGNATURE OF REFINER</p>	
<p>61. SIGNATURE OF REFINER</p>		<p>62. SIGNATURE OF REFINER</p>	
<p>63. SIGNATURE OF REFINER</p>		<p>64. SIGNATURE OF REFINER</p>	
<p>65. SIGNATURE OF REFINER</p>		<p>66. SIGNATURE OF REFINER</p>	
<p>67. SIGNATURE OF REFINER</p>		<p>68. SIGNATURE OF REFINER</p>	
<p>69. SIGNATURE OF REFINER</p>		<p>70. SIGNATURE OF REFINER</p>	
<p>71. SIGNATURE OF REFINER</p>		<p>72. SIGNATURE OF REFINER</p>	
<p>73. SIGNATURE OF REFINER</p>		<p>74. SIGNATURE OF REFINER</p>	
<p>75. SIGNATURE OF REFINER</p>		<p>76. SIGNATURE OF REFINER</p>	
<p>77. SIGNATURE OF REFINER</p>		<p>78. SIGNATURE OF REFINER</p>	
<p>79. SIGNATURE OF REFINER</p>		<p>80. SIGNATURE OF REFINER</p>	
<p>81. SIGNATURE OF REFINER</p>		<p>82. SIGNATURE OF REFINER</p>	
<p>83. SIGNATURE OF REFINER</p>		<p>84. SIGNATURE OF REFINER</p>	
<p>85. SIGNATURE OF REFINER</p>		<p>86. SIGNATURE OF REFINER</p>	
<p>87. SIGNATURE OF REFINER</p>		<p>88. SIGNATURE OF REFINER</p>	
<p>89. SIGNATURE OF REFINER</p>		<p>90. SIGNATURE OF REFINER</p>	
<p>91. SIGNATURE OF REFINER</p>		<p>92. SIGNATURE OF REFINER</p>	
<p>93. SIGNATURE OF REFINER</p>		<p>94. SIGNATURE OF REFINER</p>	
<p>95. SIGNATURE OF REFINER</p>		<p>96. SIGNATURE OF REFINER</p>	
<p>97. SIGNATURE OF REFINER</p>		<p>98. SIGNATURE OF REFINER</p>	
<p>99. SIGNATURE OF REFINER</p>		<p>100. SIGNATURE OF REFINER</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13775

CERTIFICATE OF DEATH

Reg. Dist. No.

13751

1. PLACE OF DEATH a. COUNTY <u>Hartford.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>7 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Eugene Eggers</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-59</u>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New born</u>		10c. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LUTHER EGERS</u>		14. MOTHER'S MAIDEN NAME <u>RENE SPRADLING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>*** **</u>	
17. ADDRESS <u>213 N. Union</u>		18. CITY OR TOWN <u>Havre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Antepartum & ultra partum</u> <u>768.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>uterine infection</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/20/59</u> , 19 <u>59</u> , to <u>12/20/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/20/59</u> , 19 <u>59</u> , and that death occurred at <u>5:00 PM</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>602 S. Union Ave.</u> DATE SIGNED <u>12/20/59</u>	
ACTUAL SIGNATURE <u>Richard Norment</u> M.D.		DATE SIGNED <u>12/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Richard Norment, M.D.</u>		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grove Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garrison - Chesapeake Ind.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

12/27/59

Mr. [illegible]

Home - [illegible]

12/27/59

12-20-59

12-20-59

12-20-59

12-20-59

12-20-59

12-20-59

[illegible]

12/20/59

12/20/59

12/20/59

12/20/59

12/20/59

12/20/59

12/20/59

12/20/59

12/20/59

12/20/59

12/20/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13752

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover Trace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Hanover Trace, MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>129 Union Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William C. Gerard</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kellogg Construction</u>	
11. BIRTH PLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank G. Gerard</u>		14. MOTHER'S MARDEN NAME <u>Rosalie Shanks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Carl D. Shanks</u>		Address <u>117 N. Union Ave, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Beltin, MD</u> DATE SIGNED <u>12-20-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	22b. DATE THEREOF <u>12/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>29 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

13776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED 13776		DATE OF DEATH 1960	
SEX Male		AGE 45	
PLACE OF BIRTH Bangkok		DATE OF BIRTH 1915	
OCCUPATION Teacher		EDUCATION High School	
MARITAL STATUS Married		RELIGION Buddhist	
PLACE OF DEATH Home		Circumstances of Death Natural	
Cause of Death Heart Disease		Manner of Death Natural	
Time of Death 10:00 AM		Date of Death 1960	
Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]	
Official Seal of Medical Examiner		Official Seal of Coroner	

13776

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13753

1. PLACE OF DEATH a. COUNTY <u>McC Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylor</u>		c. LENGTH OF STAY IN 1b <u>4 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Taylor</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pocock Road</u>				d. STREET ADDRESS <u>117 Lady's Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Earl Middle Hamm</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-31</u>	9. AGE (In years last birthday) <u>28</u> yrs.	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u>		11. IF UNDER 24 HRS. Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming Ash Co. Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Austin Hamm</u>				14. MOTHER'S MAIDEN NAME <u>Susan Caroline Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Korean War</u>		16. SOCIAL SECURITY NO. <u>225-34-2017</u>		17. INFORMANT <u>Mrs. Marnie Lee Hamm</u> Address <u>Mockton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound, comminuted fracture skull</u> 812X DUE TO <u>with eversion of brain</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto pedestrian type</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> a.m. <u>12-11</u> 19 <u>59</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pocock Road</u>		20f. (City or town) <u>Taylor Harford MD</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerold E Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerold E Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12-12-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Independence</u>		22d. LOCATION (City, town, or county) (State) <u>Independence Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Quigley</u>				24a. REC'D BY REGISTRAR <u>Charles C. Quigley</u>		24b. REGISTRAR'S SIGNATURE <u>Charles C. Quigley</u>	
ADDRESS <u>Farmingtonville Md.</u>				DATE <u>DEC 15 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. Name of deceased (Print name and full name of deceased person, including maiden name, if known)</p>		<p>2. Date of death (Print date)</p>	
<p>3. Place of death (Print place, street, city, county, and state)</p>		<p>4. Name of medical examiner (Print name)</p>	
<p>5. Name of physician (Print name)</p>		<p>6. Name of hospital or institution (Print name)</p>	
<p>7. Name of funeral home (Print name)</p>		<p>8. Name of undertaker (Print name)</p>	
<p>9. Name of next of kin (Print name)</p>		<p>10. Name of informant (Print name)</p>	
<p>11. Name of witness (Print name)</p>		<p>12. Name of witness (Print name)</p>	
<p>13. Name of witness (Print name)</p>		<p>14. Name of witness (Print name)</p>	
<p>15. Name of witness (Print name)</p>		<p>16. Name of witness (Print name)</p>	
<p>17. Name of witness (Print name)</p>		<p>18. Name of witness (Print name)</p>	
<p>19. Name of witness (Print name)</p>		<p>20. Name of witness (Print name)</p>	
<p>21. Name of witness (Print name)</p>		<p>22. Name of witness (Print name)</p>	
<p>23. Name of witness (Print name)</p>		<p>24. Name of witness (Print name)</p>	
<p>25. Name of witness (Print name)</p>		<p>26. Name of witness (Print name)</p>	
<p>27. Name of witness (Print name)</p>		<p>28. Name of witness (Print name)</p>	
<p>29. Name of witness (Print name)</p>		<p>30. Name of witness (Print name)</p>	
<p>31. Name of witness (Print name)</p>		<p>32. Name of witness (Print name)</p>	
<p>33. Name of witness (Print name)</p>		<p>34. Name of witness (Print name)</p>	
<p>35. Name of witness (Print name)</p>		<p>36. Name of witness (Print name)</p>	
<p>37. Name of witness (Print name)</p>		<p>38. Name of witness (Print name)</p>	
<p>39. Name of witness (Print name)</p>		<p>40. Name of witness (Print name)</p>	
<p>41. Name of witness (Print name)</p>		<p>42. Name of witness (Print name)</p>	
<p>43. Name of witness (Print name)</p>		<p>44. Name of witness (Print name)</p>	
<p>45. Name of witness (Print name)</p>		<p>46. Name of witness (Print name)</p>	
<p>47. Name of witness (Print name)</p>		<p>48. Name of witness (Print name)</p>	
<p>49. Name of witness (Print name)</p>		<p>50. Name of witness (Print name)</p>	
<p>51. Name of witness (Print name)</p>		<p>52. Name of witness (Print name)</p>	
<p>53. Name of witness (Print name)</p>		<p>54. Name of witness (Print name)</p>	
<p>55. Name of witness (Print name)</p>		<p>56. Name of witness (Print name)</p>	
<p>57. Name of witness (Print name)</p>		<p>58. Name of witness (Print name)</p>	
<p>59. Name of witness (Print name)</p>		<p>60. Name of witness (Print name)</p>	
<p>61. Name of witness (Print name)</p>		<p>62. Name of witness (Print name)</p>	
<p>63. Name of witness (Print name)</p>		<p>64. Name of witness (Print name)</p>	
<p>65. Name of witness (Print name)</p>		<p>66. Name of witness (Print name)</p>	
<p>67. Name of witness (Print name)</p>		<p>68. Name of witness (Print name)</p>	
<p>69. Name of witness (Print name)</p>		<p>70. Name of witness (Print name)</p>	
<p>71. Name of witness (Print name)</p>		<p>72. Name of witness (Print name)</p>	
<p>73. Name of witness (Print name)</p>		<p>74. Name of witness (Print name)</p>	
<p>75. Name of witness (Print name)</p>		<p>76. Name of witness (Print name)</p>	
<p>77. Name of witness (Print name)</p>		<p>78. Name of witness (Print name)</p>	
<p>79. Name of witness (Print name)</p>		<p>80. Name of witness (Print name)</p>	
<p>81. Name of witness (Print name)</p>		<p>82. Name of witness (Print name)</p>	
<p>83. Name of witness (Print name)</p>		<p>84. Name of witness (Print name)</p>	
<p>85. Name of witness (Print name)</p>		<p>86. Name of witness (Print name)</p>	
<p>87. Name of witness (Print name)</p>		<p>88. Name of witness (Print name)</p>	
<p>89. Name of witness (Print name)</p>		<p>90. Name of witness (Print name)</p>	
<p>91. Name of witness (Print name)</p>		<p>92. Name of witness (Print name)</p>	
<p>93. Name of witness (Print name)</p>		<p>94. Name of witness (Print name)</p>	
<p>95. Name of witness (Print name)</p>		<p>96. Name of witness (Print name)</p>	
<p>97. Name of witness (Print name)</p>		<p>98. Name of witness (Print name)</p>	
<p>99. Name of witness (Print name)</p>		<p>100. Name of witness (Print name)</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13754

13788

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>2 Wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 S. Main St.</u>				d. STREET ADDRESS <u>118 S. Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Hawks</u> Last <u>Hawks</u>				4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 2 1952</u>		9. AGE (In years last birthday) yrs. <u>11</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Darwin Hawks</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Bare</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Darwin Hawks</u> Address <u>Bel Air, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 22</u> , 19 <u>59</u> , to <u>Dec 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>59</u> , and that death occurred at <u>10 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air, Md</u>		DATE SIGNED <u>12-22-59</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vernon E M Miller</u> ADDRESS <u>Kislayden Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Travis</u>	

2071161XU6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 254 1-5-60 ams

13777

CERTIFICATE OF DEATH

Reg. Dist. No. 13755

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen.</u>	
c. LENGTH OF STAY IN b. <u>31 hrs.</u>		d. STREET ADDRESS <u>13 Rogers St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Halward</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH <u>12</u> Month <u>18</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 11, 1867</u>
9. AGE (In years lost birthday) <u>92</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel M. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Nowland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-12-2975</u>	
17. INFORMANT <u>Theodore Cooke Long</u> Address <u>Long Harbor Harbor, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure; Atherosclerotic Heart Disease</u> <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>II Fracture, Left Femoral Neck [FEMUR]</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-17</u> 19 <u>59</u> , to <u>12-18</u> 19 <u>59</u> , that I last saw the deceased alive on <u>12-18</u> 19 <u>59</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>608 South Union Ave., Harford, Md.</u> DATE SIGNED <u>12/18/59</u>			
ACTUAL SIGNATURE <u>Frank D. Hauber</u> M.D.		PHYSICIAN'S NAME (Type) <u>Frank D. Hauber, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>North-East Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Tarring</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

071

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13757

13778

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>—</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>411 Park Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Cecilia Eleanor Menger</i> First Middle Last				4. DATE OF DEATH <i>December 15</i> 1959 Month Day Year			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 24, 1890</i>	9. AGE (In years last birthday) <i>69</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundry work (ret'd)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lord Balto. Hotel</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Barry</i>				14. MOTHER'S MAIDEN NAME <i>Mary Bennett</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>217-03-2191</i>		17. INFORMANT <i>Mrs. Catherine Brannan, Joppa, Maryland</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fracture Skull</i> <i>816 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident & auto</i>					
20c. TIME OF INJURY Month, Day, Year <i>7</i> p. m. <i>12-15-59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rte. 40</i>		20f. (City or town) <i>Joppa</i> (County) <i>Harf</i> (State) <i>md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gerald C Palmer</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Ed A. ...</i> DATE SIGNED <i>12-16-59</i>			
EXAMINER'S NAME (Type) <i>Gerald C Palmer-MD</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12-19-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street</i> ADDRESS				24a. REC'D BY REGISTRAR <i>DEC 21 '59</i> DATE		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		Male		White		April 4, 1968		Prison, St. Louis, Mo.	
MANNER OF DEATH		CAUSE OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE		MORBID CAUSE		MORBID CAUSE	
Suicide		Firing of a bullet into the chest		Firing of a bullet into the chest		Firing of a bullet into the chest		Firing of a bullet into the chest		Firing of a bullet into the chest	
FIREARM		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON	
Revolver		.38 Smith & Wesson		.38 Smith & Wesson		.38 Smith & Wesson		.38 Smith & Wesson		.38 Smith & Wesson	
PLACE OF DEATH		CITY		COUNTY		STATE		COUNTRY		CITY	
Prison		St. Louis		St. Louis		Missouri		United States		St. Louis	
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		SECOND		DATE OF DEATH	
April 4, 1968		11:57 AM		11		57		00		April 4, 1968	
PLACE OF DEATH		CITY		COUNTY		STATE		COUNTRY		CITY	
Prison		St. Louis		St. Louis		Missouri		United States		St. Louis	
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		SECOND		DATE OF DEATH	
April 4, 1968		11:57 AM		11		57		00		April 4, 1968	

File 6-3101

APR 11 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hairford</u> 13779 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u>		c. LENGTH OF STAY IN 1b <u>Liberty Grove</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hairford Memorial Hospital</u>		e. STREET ADDRESS <u>07X-2</u>	
3. NAME OF DECEASED (Type or print) <u>Rosemarie</u> First <u>Baby Boy</u> Middle <u>Moulton</u> Last		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1959</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert M. Moulton Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Stella Faye Wyatt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Robert M. Moulton Jr., Liberty Grove, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aspiration vomitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louise C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bellair, Md</u>	
EXAMINER'S NAME (Type) <u>Gerrard Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-26-59</u>	
22a. BURIAL CREMATION, REBURY (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Bridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colora, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Debra Patterson & Son</u>		ADDRESS <u>Perryville, Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2071213XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13789

CERTIFICATE OF DEATH

Reg. Dist. No.

13758

1. PLACE OF DEATH a. COUNTY <i>Harford Maryland</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Long Beach Harbor</i> c. LENGTH OF STAY IN 1b <i>2 yrs.</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Long Beach Harbor</i> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Margaret M. Page</i> First Middle Last 4. DATE OF DEATH <i>12/5/59</i> Month Day Year				5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>3/30/1874</i> 9. AGE (In years, lost birthday) <i>85</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>none</i> 11. BIRTHPLACE (State or foreign country) <i>Mo. Holly Mo.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Martin J. Brady</i> 14. MOTHER'S MAIDEN NAME <i>Margaret Power</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <i>Margaret M. Lettinger, Nantux, Pa</i> Address <i>804 Chauncey Road</i>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X Generalized Circulatory Failure</i> DUE TO (b) <i>Cerebral Thrombosis</i> DUE TO (c) <i>Cerebral Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>36 hours</i> <i>17 days</i> <i>5 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <i>10-6-</i> , 19 <i>58</i> , to <i>12-5-</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-5-</i> , 19 <i>59</i> , and that death occurred at <i>1:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Peter P. Rodman</i> M.D. <i>8</i> ADDRESS (Street, city or town, state) <i>Law St. -</i> DATE SIGNED _____				PHYSICIAN'S NAME (Type) <i>Peter P. Rodman, M.D.</i> <i>Aberteen, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>12/9/59</i> 22b. DATE THEREOF <i>St. Mary's</i> 22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i> 22d. LOCATION (City, town, or county) (State) <i>Mo. Holly Mo.</i>				23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. P. M., Harford Co., Md.</i> ADDRESS _____ 24a. REC'D BY REGISTRAR <i>DEC 10 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

CERTIFICATE OF DEATH

1978

RECORDED
INDEXED
JAN 11 1979
BALTIMORE, MARYLAND

DECEASED NAME LAST FIRST MIDDLE (Print or type name in full)	
SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
AGE YEARS MONTHS DAYS (Print or type age in full)	
DATE OF DEATH MONTH DAY YEAR (Print or type date in full)	
PLACE OF DEATH (Print or type place in full)	
CAUSE OF DEATH (Print or type cause in full)	
MANNER OF DEATH (Print or type manner in full)	
SIGNATURE OF DECEASED (Print or type signature)	
SIGNATURE OF WITNESS (Print or type signature)	
SIGNATURE OF PHYSICIAN (Print or type signature)	
SIGNATURE OF CORONER (Print or type signature)	
SIGNATURE OF JUDGE (Print or type signature)	
SIGNATURE OF CLERK (Print or type signature)	

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13790 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					14367				
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY Mercy				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Rt. 40					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trenton 67x-3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS 219 E. Hanover				
3. NAME OF DECEASED (Type or print) JEREMIAH First PETRICK Middle PETrick Last					4. DATE OF DEATH December 25 19 59 Month Day Year				
5. SEX Male		6. COLOR OR RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1934		9. AGE (In years last birthday) 25 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer			10b. KIND OF BUSINESS OR INDUSTRY Home const.			11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sidney Patrick					14. MOTHER'S MAIDEN NAME Della Wilson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)			16. SOCIAL SECURITY NO. 250-54-3170		17. INFORMANT Vernee Floyd		Address Trenton, N.J.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 816X DUE TO and Conditions, if any, which gave rise to immediate cause (b) second and third degree body burns (c) DUE TO cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Auto-bus accident						
20c. TIME OF INJURY Month, Day, Year 10:00 a.m. Dec. 25 1959			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Edgewood (County) Harford (State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Petty M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Charles S. Petty					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					DATE SIGNED 12/26/59				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial			22b. DATE THEREOF 12-30-59		22c. NAME OF CEMETERY OR CREMATORY Conway Cem		22d. LOCATION (City, town, or country) (State) Conway S.C.		
23. FUNERAL DIRECTOR McKiener Funeral Home ADDRESS 1408 Race Path Ave., Conway, S. C.					24a. REC'D BY REGISTRAR JAN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

11

Charles S. Peabody

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, telephone call-Lassahn Funeral Home 12/24/59, acc.

13791

CERTIFICATE OF DEATH

Reg. Dist. No. 13759

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JOPPA MD.				c. LENGTH OF STAY IN 1b 10 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT. 1. Box 252A JOPPA MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES WILLIAM RASPE				4. DATE OF DEATH Month Day Year December 17 19 59.			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 17, 1889	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST				10b. KIND OF BUSINESS OR INDUSTRY ARMY CHEM. CENTER. MARYLAND.		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOHN H RASPE JR.				14. MOTHER'S MAIDEN NAME MARGARET RAVADGE.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-03-8007			
17. INFORMANT MRS CHARLES RASPE				Address Box 252A JOPPA MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal tumor (left kidney) with metastases to lung DUE TO (b) 180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 12 months.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-30 , 19 54 , to 12-17- , 19 59 , that I last saw the deceased alive on 12-16 , 19 59 , and that death occurred at 4:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Fred O. Hodous				ADDRESS (Street, city or town, state) Edgewood, Md			
PHYSICIAN'S NAME (Type) Fred O. Hodous				DATE SIGNED 12-18-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF DEC 19, 1959.		22c. NAME OF CEMETERY OR CREMATORY JERUSALEM.	
22d. LOCATION (City, town, or county) (State) JOPPA MARYLAND							
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd				24a. REC'D BY REGISTRAR DATE DEC 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

12721

CENTRAL AVE. OF DEATH

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

12721

CERTIFICATE OF DEATH

Reg. Dist. No.

13760

13780

1. PLACE OF DEATH a. COUNTY <i>Darford</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Arm</i> <i>03X-2</i>	
3. NAME OF DECEASED (Type or print) First <i>Agnes</i> Middle <i>T</i> Last <i>Reamy</i>		4. DATE OF DEATH Month <i>December</i> Day <i>27</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-17-86</i> <i>Maryland</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland (Baltimore)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frank Martin</i>		14. MOTHER'S MAIDEN NAME <i>Mary Doyle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> <i>Julian G. Reamy - same - husband</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Blood Loss Shock</i> DUE TO (b) <i>Ruptured Abdominal Aorta</i> DUE TO (c) <i>Aneurysm</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs</i> <i>2-3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2:35 AM</i> <i>12/27/1959</i> to <i>1:15 PM</i> <i>12/27/59</i> , that I last saw the deceased alive on <i>12/27</i> <i>1959</i> , and that death occurred at <i>1:15 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. Sadowsky</i>		ADDRESS (Street, city or town, state) <i>504 LEWIS ST. Harre de Grace, Md.</i>	
PHYSICIAN'S NAME (Type) <i>W. H. SADOWSKY</i>		DATE SIGNED <i>12/27/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12-30-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Long Green, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Cook, Inc., 1217 St. Paul Street</i>		24a. REC'D BY REGISTRAR <i>DEC 29 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED BY THE DEPARTMENT OF HEALTH

1935

[Faint, mostly illegible handwritten text, possibly a letter or report.]

[Faint, mostly illegible handwritten text, possibly a signature or date.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13792 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 7 Film 254 1-13-60 et											
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE New Jersey b. COUNTY Mercy					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Rt. 40						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trenton 67x-3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS 632 Princeton Ave					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) HENRY L. RIGGINS						4. DATE OF DEATH December 25 1959					
5. SEX Male		6. COLOR OR RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 1935		9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dish Washer		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Glennie Riggins						14. MOTHER'S MAIDEN NAME Alice Mc Cray					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. Vernee Floyd					
17. INFORMANT Trenton N.J.						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 816x DUE TO and Conditions, if any, which gave rise to immediate cause (b) second and third degree body burns (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-bus Accident					
20c. TIME OF INJURY Month, Day, Year 10:00 a.m. Dec 25 1959						20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway						20f. (City or town) Edgewood (County) Harford (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Charles S. Petty						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						DATE SIGNED 12/26/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial						22b. DATE THEREOF 12-30-59					
22c. NAME OF CEMETERY OR CREMATORY Conway Cem						22d. LOCATION (City, town, or country) (State) Conway S.C.					
23. FUNERAL DIRECTOR, ADDRESS McHenry Funeral Home						24a. REC'D BY REGISTRAR JAN 7 '60					
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

1408 Race Path Ave., Conway, S.C.

1/20

FOR BIRTH
DATE
1911

13133

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

Charles J. Taylor

1911

1911

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13793

CERTIFICATE OF DEATH

Reg. Dist. No.

13761

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EMMORTON</u>				c. LENGTH OF STAY IN 1b <u>35 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edgewood Rd. Box 381</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Constance</u> Middle <u>Poor</u> Last <u>Stump</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 13-1899</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>	
13. FATHER'S NAME <u>HENRY W. POOR</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-22-1468</u>		17. INFORMANT <u>John W. Stump</u> Address <u>Edgewood Rd. Box 381</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of esophagus.</u> DUE TO <u>spreading to lymphatic system</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April</u> , 19 <u>59</u> to <u>Dec. 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 13</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Richardson</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Charles Richardson M.D.</u>				DATE SIGNED <u>Bel Air, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec. 15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>EMMORTON Hartford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> ADDRESS <u>Bel Air Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>	

CERTIFICATE OF DEATH

15793

<p>1. NAME OF DECEASED <i>John W. Smith</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>65</i></p>		<p>4. DATE OF BIRTH <i>Jan 15, 1893</i></p>		<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>6. OCCUPATION <i>Retired</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF DEATH <i>Dec 10, 1958</i></p>		<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>11. MEDICAL HISTORY <i>None</i></p>		<p>12. PRESENT ILLNESS <i>None</i></p>		<p>13. DATE OF EXAMINATION <i>Dec 10, 1958</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>John W. Smith</i></p>		<p>15. SIGNATURE OF REGISTRAR <i>John W. Smith</i></p>	
<p>16. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>17. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>18. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>19. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>20. SIGNATURE OF DECEASED <i>John W. Smith</i></p>	
<p>21. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>22. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>23. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>24. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>25. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>	
<p>26. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>27. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>28. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>29. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>30. SIGNATURE OF DECEASED <i>John W. Smith</i></p>	
<p>31. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>32. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>33. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>34. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>35. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>	
<p>36. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>37. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>38. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>39. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>40. SIGNATURE OF DECEASED <i>John W. Smith</i></p>	
<p>41. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>42. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>43. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>44. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>45. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>	
<p>46. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>47. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>48. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>49. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>50. SIGNATURE OF DECEASED <i>John W. Smith</i></p>	
<p>51. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>52. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>53. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>54. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>55. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>	
<p>56. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>57. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>58. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>59. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>60. SIGNATURE OF DECEASED <i>John W. Smith</i></p>	
<p>61. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>62. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>63. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>64. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>65. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>	
<p>66. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>67. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>68. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>69. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>70. SIGNATURE OF DECEASED <i>John W. Smith</i></p>	
<p>71. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>72. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>73. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>74. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>75. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>	
<p>76. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>77. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>78. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>79. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>80. SIGNATURE OF DECEASED <i>John W. Smith</i></p>	
<p>81. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>82. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>83. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>84. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>85. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>	
<p>86. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>87. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>88. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>89. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>90. SIGNATURE OF DECEASED <i>John W. Smith</i></p>	
<p>91. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>92. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>93. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>94. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>95. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>	
<p>96. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>97. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>98. SIGNATURE OF DECEASED <i>John W. Smith</i></p>		<p>99. SIGNATURE OF WITNESSES <i>John W. Smith</i></p>		<p>100. SIGNATURE OF DECEASED <i>John W. Smith</i></p>	

1. Name of Deceased
2. Sex
3. Age
4. Date of Birth
5. Place of Birth
6. Occupation
7. Marital Status
8. Date of Death
9. Place of Death
10. Cause of Death
11. Medical History
12. Present Illness
13. Date of Examination
14. Signature of Physician
15. Signature of Registrar
16. Signature of Deceased
17. Signature of Witnesses
18. Signature of Deceased
19. Signature of Witnesses
20. Signature of Deceased
21. Signature of Witnesses
22. Signature of Deceased
23. Signature of Witnesses
24. Signature of Deceased
25. Signature of Witnesses
26. Signature of Deceased
27. Signature of Witnesses
28. Signature of Deceased
29. Signature of Witnesses
30. Signature of Deceased
31. Signature of Witnesses
32. Signature of Deceased
33. Signature of Witnesses
34. Signature of Deceased
35. Signature of Witnesses
36. Signature of Deceased
37. Signature of Witnesses
38. Signature of Deceased
39. Signature of Witnesses
40. Signature of Deceased
41. Signature of Witnesses
42. Signature of Deceased
43. Signature of Witnesses
44. Signature of Deceased
45. Signature of Witnesses
46. Signature of Deceased
47. Signature of Witnesses
48. Signature of Deceased
49. Signature of Witnesses
50. Signature of Deceased
51. Signature of Witnesses
52. Signature of Deceased
53. Signature of Witnesses
54. Signature of Deceased
55. Signature of Witnesses
56. Signature of Deceased
57. Signature of Witnesses
58. Signature of Deceased
59. Signature of Witnesses
60. Signature of Deceased
61. Signature of Witnesses
62. Signature of Deceased
63. Signature of Witnesses
64. Signature of Deceased
65. Signature of Witnesses
66. Signature of Deceased
67. Signature of Witnesses
68. Signature of Deceased
69. Signature of Witnesses
70. Signature of Deceased
71. Signature of Witnesses
72. Signature of Deceased
73. Signature of Witnesses
74. Signature of Deceased
75. Signature of Witnesses
76. Signature of Deceased
77. Signature of Witnesses
78. Signature of Deceased
79. Signature of Witnesses
80. Signature of Deceased
81. Signature of Witnesses
82. Signature of Deceased
83. Signature of Witnesses
84. Signature of Deceased
85. Signature of Witnesses
86. Signature of Deceased
87. Signature of Witnesses
88. Signature of Deceased
89. Signature of Witnesses
90. Signature of Deceased
91. Signature of Witnesses
92. Signature of Deceased
93. Signature of Witnesses
94. Signature of Deceased
95. Signature of Witnesses
96. Signature of Deceased
97. Signature of Witnesses
98. Signature of Deceased
99. Signature of Witnesses
100. Signature of Deceased

13781

CERTIFICATE OF DEATH

Reg. Dist. No.

13762

1. PLACE OF DEATH a. COUNTY MARYLAND HARFORD				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUCE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising SUN .07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRED First EDWARD Middle Sutphin Last				4. DATE OF DEATH Month DECEMBER Day 21 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-17-1905	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emett Sutphin				14. MOTHER'S MAIDEN NAME Lillie Kemp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-07-6806		INFORMANT Harry E. bid Sutphin		Address Rising Sun, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 237X DUE TO Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Poss brain tumor DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 48 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/7 , 19 59 , to 12/21 , 19 59 that I last saw the deceased alive on 12/21 , 19 59 , and that death occurred at 3:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Neil Taylor M.D.				ADDRESS (Street, city or town, state) Rising Sun, Md		DATE SIGNED 12/21/59	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-59		22c. NAME OF CEMETERY OR CREMATORY North East Methodist		22d. LOCATION (City, town, or county) (State) North East Cecil, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East Md		24a. REC'D BY REGISTRAR DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13782

CERTIFICATE OF DEATH

Reg. Dist. No.

13763

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE 24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL TUCKER</u>				4. DATE OF DEATH Month Day Year <u>DEC 20 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 20, 1959</u>	
9. AGE (In years last birthday) <u>one day</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>15</u>		IF UNDER 24 HRS. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEW BORN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>HARFORD HOSP. MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>JAMES STERLING TUCKER</u>				14. MOTHER'S MAIDEN NAME <u>DOROTHY ANN CARLILE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (28 weeks) of 776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 20</u> , 19 <u>59</u> , to <u>Dec 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>114 W. Bel Air Ave</u> DATE SIGNED <u>Hardeen, Md</u> ACTUAL SIGNATURE <u>Andre Weiss</u> M.D. PHYSICIAN'S NAME (Type) <u>ANDRE WEISS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>REMOVED (Specify)</u>		<u>12-20-59</u>		<u>HARFORD MEMORIAL HOSPITAL</u>		<u>Haure de Grace Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Zuby Administrator</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071201XUO

1878

EXTRACT OF A LETTER

RECEIVED AT THE ALBANY OFFICE - JANUARY 1878

11

JAN 10 1878

JAN 10 1878

JAN 10 1878

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

11

WILLIAM C. BAKER, JR.

WILLIAM C. BAKER, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

VS AIS (4)
ISM 9/58

1
X
M
071
1
0
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13783
CERTIFICATE OF DEATH

Reg. Dist. No. 13764

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVE DE GRACE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 3401-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN Thomas WATTS		4. DATE OF DEATH Month Day Year DECEMBER 23 1959	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 28 1904 9. AGE (In years lost birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Man		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	11. BIRTHPLACE (State or foreign country) Prince Edward county 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HARLAND WATTS		14. MOTHER'S MAIDEN NAME Mildred Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-3125	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular - renal disease (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? INTERVAL BETWEEN ONSET AND DEATH Since 11/20/59		INFORMANT Mrs Ida S. Watts 3117 Presbury St Address	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 20th, 1959, to Dec. 23rd, 1959, that I last saw the deceased alive on Dec. 23rd, 1959, and that death occurred at 8:05 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward C. Foo, M.D.		DATE SIGNED 12/23/59	
PHYSICIAN'S NAME (Type) Edward C. Foo, M.D.		ADDRESS (Street, city or town, state) 211 N. Union Ave. Harve de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/59	22c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter		24a. REC'D BY REGISTRAR DEC 29 59 24b. REGISTRAR'S SIGNATURE Arthur S. Krane	

1758

17

1

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections, with some lines being underlined. The handwriting is cursive and typical of the 18th century.]

13794

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>				c. LENGTH OF STAY IN 1b <u>28 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LETTIE</u> Middle <u>RUTH</u> Last <u>ZELLMAN</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 14, 1914</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>ROBERT G. HALL</u>			
14. MOTHER'S MAIDEN NAME <u>LAURAB. ROBERTS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>			
16. SOCIAL SECURITY NO. <u> </u>				INFORMANT <u>FREDERICK A. ZELLMAN</u> Address <u>HAVERDE GRACE</u> <u>NO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple pulmonary emboli</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Carcinoma of Cervix - with metastases</u> DUE TO (c) <u>metastases</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MAUNUTRITION, RENAL SHUTDOWN</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>October 15, 1959</u> , to <u>December 22, 1959</u> , that I last saw the deceased alive on <u>December 18, 1959</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond J. Donovan, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>200 N. Union Ave. Haverde Grace Md.</u>		DATE SIGNED <u>12-22</u>	
PHYSICIAN'S NAME (Type) <u>RAYMOND J. DONOVAN, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 26, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK RON</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>Haverde Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13792

1

1